STATEMENT OF REASONS
FOR RULE CHANGES UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

As required by Section 11346.2 of the Government Code, the Commissioner of Corporations ("Commissioner") sets forth below the reasons for the proposed amendment to Sections 1300.68 and the adoption of Section 1300.68.01 of the California Code of Regulations (10 C.C.R. Sec. 1300.68 and 1300.68.01).

Under the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act) health care service plans ("plans") are required to establish and maintain a grievance system to resolve enrollee complaints against plans regarding health care services. The Knox-Keene Act also allows enrollees to file complaints against plans with the Department of Corporations ("Department"), and establishes a statutory process for resolving complaints with the Department.

Senate Bill 189 (Chapter 542, Stats. 1999) among other things, amended the Knox-Keene Act to: reduce the period of time, from 60 to 30 days, in which plans and the Department have to review and resolve enrollee complaints; allows enrollees to seek the Department's review of unresolved grievances after 30 days (instead of the current 60 days), and requires plans to act on emergency grievances, including those involving severe pain, within 3 days of receipt of the grievance (instead of the current 5 days).

In accordance with the changes to the statute made by SB 189, the Commissioner has determined that changes to Section 1300.68 were necessary. These changes will enable the Department to respond to the requirements of the Legislature to resolve enrollee complaints within 30 days.

Section 1300.68 requires plans to establish a grievance system and sets forth the quarterly report form for pending and unresolved grievances. The Commissioner proposes to amend Section 1300.68 to implement the changes made by SB 189.

Subsection (a) is being amended to clarify that plans should resolve grievances within 30 calendar days of receipt of the grievance by the plan or the entity delegated by the plan to resolve grievances, and to provide definitions for the terms "grievance," "complaint," "complainant," and "resolved".

Subsection (a) is being amended to clarify and specify the timeframe in which plans are to resolve grievances and the event that signifies the beginning of the 30-day review and resolution period. These changes will provide clarity and consistency throughout the health plan industry with respect to the plans' grievance system. The alternative of requiring resolution of grievances in 30 business days was rejected as not meeting the intent of the SB 189 which is to resolve grievances in a more expeditious manner and to ensure that the enrollee is receiving medically necessary health care services in a timely manner.

The Commissioner proposes defining and adding the definitions for "grievance," "complaint," "complainant, and "resolved" to subsection (a). These definitions are necessary for clarity and consistency, and will enable plans to understand what is required with respect to the grievance process and the quarterly reporting requirements.

"Grievance" is defined to include any complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. It is necessary to define "grievance" as some plans do not consider complaints, disputes, requests for reconsideration or appeals to be grievances.

Grievance is further defined to clarify that when the plan is unable to distinguish between a grievance and inquiry, they shall be considered a grievance. This statement was moved from new subsection (b)(7) (former subsection (g)).

"Complaint" is defined to have the same meaning as "grievance".

"Complainant" is defined to mean the person who files the grievance, whether on his or her own behalf or on the behalf of the enrollee.

"Resolved" is defined to mean finally decided with no further opportunity for appeal to the plan.

The remainder of subsection (a) is being moved to new subsection (b). Grammatical and format changes are also being made to this subsection, (i.e., former subsections (b) through (h) have been renumbered subsection (b), paragraphs (2) through (8)).

Health and Safety Code Section 1368(a)(5) requires plans to keep all copies of grievances and responses thereto for five years. Paragraph (9) is being added to new subsection (b) to specify that copies of the medical records, documents, evidences of coverage and other relevant information that the plan used to reach its decision, be maintained with the grievance file.

Paragraph (9) works in conjunction with proposed subsection (c). As part of this rulemaking, proposed subsection (c) will require plans to submit specified information to the Department within 5 calendar days of a request from the Department, when the Department receives a grievance from an enrollee who does not agree with the plan's decision or who has participated in the plan's grievance system for 30 days. Compliance with paragraph (9) will enable a plan to avoid unnecessary effort and cost in gathering the requested information, which will facilitate the Department's timely review.

Health and Safety Code Section 1368.01(b) requires that the plan's grievance system include a requirement for expedited review of cases involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function. Subsection (10) is being added to subsection (a) to clarify that the plan's grievance system is also to include procedures for the expedited review of grievances. This subparagraph is needed to clarify the requirements of Health and Safety Code Section 1368.01.

Subsection (b) of Health and Safety Code Section 1368 allows an enrollee to submit a grievance to the Department for review after the enrollee has completed the plan's grievance system or after participating in the plan's grievance system for 30 days. The Commissioner proposes adopting new subsection (c) to set forth procedures and the information that the plan is required to submit to the Department. Specifically, the plan is required to submit information that it used to reach a decision with respect to an enrollee's grievance within five calendar days after receipt of written notification from the Department. Failure to provide the Department with the requested information within five calendar days may result in the Department ruling in the enrollee's favor on any issue that the Department cannot decide because it does not have the information to make a determination.

The requirement that the plan submit specified information within five calendar days is necessary in order for the Department to review and respond to an enrollee's complaint within the required 30-day period. (SB 189 changed the timeframe in which the Department has to resolve grievances from 60 days to 30 days.) Any delay by the plan in providing necessary information to the Department hinders the Department from an adequate review of the complaint within the 30-day period. This requirement is necessary to notify plans that the failure to provide information in the required time may result the Department ruling in favor of the enrollee. Moreover, this is the same information that the plan uses in reaching its decision or formulating its response to the enrollee's complaint. The alternative of allowing the plan to provide the requested information at the plan's convenience was rejected. That alternative compromises the Department's review of a grievance and may place the Department out of compliance with the requirements of Health and Safety Code Section 1368.

Health and Safety Code Section 1368 requires plans to submit a quarterly report of grievances which are pending and unresolved for 30 days or more. Subsection (d) sets forth the procedures for the quarterly report. A plan is not required to report grievances filed and processed outside of the plan's grievance system. Paragraph (1) of subsection (d) is amended to expand the list of outside review organizations to include the Center for Dispute Resolution, an independent review organization, and the Department of Social Services (fairness hearings for Medi-Cal enrollees). The changes to paragraph (1) provide additional clarification with respect to the reporting requirements of the quarterly report.

The Quarterly Report of Pending and Unresolved Grievances is contained in paragraph (6) of subsection (d) of Section 1300.68. Item 3 of the report is being amended to request the total plan enrollment information for each category, i.e., number of Commercial, Medicare (Risk), Medicare (Supplement) and Medi-Cal enrollees. This information is necessary to determine the percentage of complaints within specific category and will provide information to monitor plan performance.

Throughout Section 1300.68, the term "complaint" is changed to "grievance". This is necessary for clarity and consistency throughout the rule.

The Commissioner proposes adopting Section 1300.68.01 to clarify procedures for the expedited review of grievances ("urgent and emergency requests"). This section is needed to implement Health and Safety Code Section 1368.01, which requires plan grievance systems to include a requirement for the expedited review of grievances.

Subsection (a) clarifies the minimum requirements to be included in the plan's procedures for expedited review. This subsection is necessary to clarify the plan's responsibility in urgent and emergency requests, and includes clarification that the enrollee's medical condition shall be considered when determining the plan's response time.

Subsection (b) requires the grievance system to provide a primary contact person and at least two back-up contact persons who will handle urgent and emergency requests. The contact persons must have the authority to authorize and/or intervene in health care services and treatment and financial decisions on behalf of the plan without having to obtain further approval from the plan. This subsection requires the contact persons to respond to the Department within a specific timeframe.

Subsection (c) requires plans to provide the Department with the plan's organizational information with respect to urgent and emergency requests; the names, titles, telephone numbers, pager numbers, answering service or voice mail numbers, and e-mail addresses, for contacting the primary and the back-up contact persons; and a monthly duty roster for the primary and back-up contact persons. Plans are required to notify the Department when there are any changes to contact person information or to the monthly duty roster.

Subsections (b) and (c) are necessary because immediate assistance is typically required in cases involving imminent and serious threat to the health of the enrollee.

The requirement that plans submit a list of contact persons and their contact numbers arose from situations where the Department was unable to contact anyone in the plan's organization to assist in an urgency matter.

In one case, a nurse consultant for the Department made a series of calls in an attempt to reach a responsible official at the plan, including the plan-designated urgent Request for Assistance contact persons for both Southern and Northern California. The nurse consultant left voice mails for each, but received no response. The nurse consultant then called the general statewide plan member services telephone number. The representative at that number told her that many people were unavailable because of the holiday, and that there were no other people for her to contact besides those she had tried. The enrollee was receiving dialysis for acute renal failure in addition to cardiac care. Despite concerns over the state of the enrollee's health, the enrollee was transferred from one facility and upon arrival at the plan's facility, was put in a non-acute ward with no heart monitor. He subsequently went into cardiac arrest within an hour after his arrival and died.

With these procedures in place, the chance of this situation re-occurring will be minimized.

ALTERNATIVES CONSIDERED

No alternative considered by the Department would be more effective in carrying out the purpose for which the regulation is proposed, would be as effective and less burdensome to affected private persons, or would lessen any adverse impact on small businesses.

FISCAL IMPACT

Cost to Local Agencies and School Districts required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None.

No other nondiscretionary cost or savings are imposed on local agencies.

DETERMINATIONS

The Commissioner has determined that the proposed regulatory action does not impose a mandate on local agencies or school districts, which require reimbursement pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code.